Written Statement
of
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Good morning Senators, panel members and ladies and gentlemen in the audience. My name is Judith Ryan, and I am the President and CEO of The Evangelical Lutheran Good Samaritan Society. The Society has been caring for our frail elderly and disabled citizens for more than 78 years. As a registered nurse and former Executive Director of the American Nurses Association, I know as well as anyone, the direct relationship between nursing staff and the quality of care, and I grapple everyday with what can only be characterized as a major crisis for our profession. That crisis is caused by a confluence of circumstances that have struck the nursing home community with a devastating force.

I am here today as a representative of the American Health Care Association, a federation of state associations representing over 12,000 non-profit and for-profit assisted living, nursing facility, and sub-acute providers nationally.

Over these past several months, I have spent concentrated time in more than 80 of our nursing centers, including one week working alongside our CNA's and front line staff caring for residents. I know from direct experience that the individuals we entrust to care for our parents and loved ones spend their days in what are among the hardest jobs in the American workforce. The work of caregiving is demanding both physically and emotionally. The residents in today's nursing facilities require a range of care from complex medical treatment to support with daily activities, to specialized approaches in the management of dementia. Our professional and compassionate commitment needs to remain focused on helping our residents age with optimal function and dignity.

Unfortunately, negative nursing home images created, particularly in this past year, have served to enhance society's lack of recognition for the value of our elderly's most precious resource; those who care for them. If we can agree on that, then we can begin to work together.

Together, government, advocates, and providers must recognize their individual and collective responsibility to ensure adequate numbers of qualified and competent staff to care for our residents. We must agree to stop the vilification of nursing homes, and we must agree to use the regulatory system to help caregivers find ways to improve the quality of care rather than to add non-value-added cost and the burden of fear to their already difficult work.

**Care providers today**

The face of nursing facilities looks very different in 1999 than it did ten years ago and promises to change even more dramatically in the future as 77 million baby boomers prepare to retire. Today, a nursing facility is no longer just a building that provides a homelike setting in which the elderly, needing assistance with their activities of daily living, reside. In 1999, nursing facilities provide a vast array of services to a very diversified population of health care clients.

Patients and residents cover the entire age spectrum from children to adults to the frail elderly. They enter the nursing facility with diagnoses, clinical conditions and care needs which range from ventilator dependency to intensive rehabilitation post stroke to need for specialized dementia management, as well as the more traditional need for assistance with routine functions of daily living.

We should all agree that adequate staffing means being responsive to the individualized needs of

residents. This need differs from resident population to resident population and from facility to facility. I have described below the three essential issues that the long term care community believes must be carefully considered in any policy decisions related to staffing: access to and availability of nursing staff, sufficient payment to support adequate staffing, and facility-specific or patient population specific staffing standards based on resident acuity or need for care.

**Access and Availability of Nursing Staff**

Staffing shortages are prevalent across the nation and across health care settings. Shortages exist for the registered nurse (RN), licensed practical nurse (LPN) and certified nursing assistant (CNA). For example:

Licensed Nurses- (Registered Nurses and Licensed Practical Nurses)

- The average RN is now 42 years old in the acute care setting and 45 in the nursing home setting. At the same time, nursing school enrollments decreased 17% in the past four years. As larger numbers of nurses retire, there will be fewer newcomers to take their place and the competition will be "fierce" across all levels.
- In 1999 we have seen nurses at all levels giving up their jobs in nursing facilities because of the image of nursing facilities and the implied message that they are not doing a good or important job.
- Additional health care settings are emerging to meet the needs of specialized elder care. Therefore, the demand for nursing staff continues to grow as the supply diminishes.
- Elderly patients account for more than 80 percent of health care in all settings, and nursing educational programs are not adequately preparing students for their care. 60% of the nursing programs have no full-time faculty members with ANA certification in gerontology. This discourages new nurses from being exposed to the long-term care setting and the issues we face.

**Certified Nursing Assistants**

Within the Good Samaritan Society, turnover among all employees was 54% in l998. Turnover of CNA's was 77%. When we looked deeper into our statistics, we learned that we have a very stable core of Certified Nursing Assistants. Many of them have served with the Society for more than 25 years. However, our turnover among new staff was extremely high. We are, therefore, working closely with our core staff to develop strategies to recruit and retain new caregivers.

- Senior managers are required to spend two days each year working directly with caregivers, so that we better understand the work in which our staff are engaged and experience the mission of the Society in the field.
- We have enlisted the help of Resident Councils and Community Advisory Councils at each of our facilities in identifying potential sources of new staff, confident that those who know us best know about the quality of our care and work environment.
- We have made a tremendous investment in learning resources, focusing first on mandatory skills and knowledge requirements that are work related, but moving quickly into life skills development and opportunity to gain academic and professional credentials. For example, in one facility we are teaching a certified course in Women's Survival Skills, a curriculum developed by women who have moved off welfare and into the work force for those aspiring to do the same.
- We are working with our front line staff to develop orientation programs for new recruits, including mentoring programs, preceptor programs, 'buddy' systems, and staff involvement in early resident assignments of new staff.

- We are paying the full cost of certification and continuing education--in many cases, on Society time.
- The Society has taken leadership in introducing 'pass through' legislation for wages and salaries within state Medicaid payment statutes.
- We conduct bedside memorial services as one means of helping staff deal with their sense of grief and loss following the death of a resident
- We are more directly involving CNA's in our quality assurance and improvement teams, respecting their knowledge of the resident's care needs and ways in which we might improve the quality of that care
- We are providing Spanish as a Second Language courses in our facilities in which most of our residents and staff are Hispanic
- We have created a 'Fall Prevention Unit', to which residents at high risk are assigned, and on which CNA's are assigned to spend individual time with these residents, reading with them, listening to their stories, etc.
- We are supporting unique programs that address the disadvantaged population, e.g., use of the Work Opportunity Tax Credit and CNA training programs that recruit new immigrants and provide specialized educational needs.
- And, we are working to obtain adequate Medicaid reimbursement to meet the level of staffing necessary to meet the individualized needs of the residents.

The Evangelical Lutheran Good Samaritan Society serves primarily in small, deeply rural settings. The numbers of old, old are disproportionately high in these areas. Old women are being cared for by old women. We have CNA's still actively employed who are 79 years old; and volunteers in their late 80ies serving in senior companion roles are very common.

Wives in many of these rural families are working, caring for children, and caring for older parents. Children in these communities are leaving home for college and for work in urban areas. We do not have access to the numbers of front line caregivers we need.

The profound impact of the growth of the aging population, the lowest unemployment rate in 29 years, with 2 in 5 American's literacy at or below 8$^{th}$ grade, in which new immigrants make up ½ the US workforce increase, and in which 3 of 4 couples both spouses are employed, 62% of moms with kids under age 3 are employed and only 50% of men, 55-64, are still in the labor force, providers, advocates and citizens must be willing to 'think outside of the box' about staffing in nursing homes.

Perhaps the most creative things we are doing to address the access issues include:

We are working with a high school in Howard South Dakota, through a grant provided by the Annenberg Foundation to secondary education, to redesign what the rural community of the future should look like, and specifically, how such a community would envision caring for its elders.

We are partnering with community colleges and state universities to bring formal education opportunities into the rural community through distance learning

We have moved into a self-insurance program for health benefits, stressing access to primary care for children and young adults and access to employee assistance services.

**Reimbursement must support adequate staffing**

Medicaid is the primary source of funding for nearly 68% of all nursing facility residents. Another 9%

rely on Medicare. Only 3% of nursing facility residents are covered by private insurance. Since 1989, nursing facilities share of Medicaid and Medicare dollars have been dwindling.

In addition, the repeal of the Boren Amendment gives states more flexibility to reduce reimbursement rates and limit payment increases. Under Boren, state Medicaid payments to nursing facilities had to be "reasonable and adequate to meet the cost of efficiently and economically operated facilities." Since repeal, many states have sought to lower their payment rates and several have succeeded. More common still, are the lack of payment adjustments as inflation and other costs of care increase. This lack of payment guarantees will make it easier for states to reduce Medicaid reimbursement rates, which will result in limited payment for labor cost.

Simultaneously, the new Medicare PPS has been demonstrated to significantly under pay for the cost of care in several high acuity and rehabilitative categories. This reduction in Medicare revenues places additional pressure on the already under funded Medicaid program and limits a SNFs financial ability to provide necessary wage and staffing increases.

The fundamental goal of a case mix payment system is to adjust the providers' revenues to reflect the residents' changing needs for services or care. With regard to the staffing issue, it becomes critical that the fundamental goal of a sound payment system is not sacrificed by Medicare and Medicaid budgetary constraints as opposed to meeting resident needs.

There should be no discussion of mandated increases in staffing levels without simultaneous discussion of funding additional mandated staff.

**Determining Staffing Levels**

There is not one staffing level (or even minimum ratio) that is appropriate for all nursing facilities. But there is one level appropriate for each resident population and perhaps, facility. It is essential that any mandated staffing standards be determined based upon the needs of the residents in that particular facility during a specified time.

One way to determine the case-mix and acuity level in facilities is through use of the Minimum Data Set (MDS). The MDS has been utilized to generate Quality Indicators (QIs) which will measure outcomes and quality in nursing facilities. Hopefully, these quality indicators will provide a linkage between quality of care and adequate staffing. By tracking resident characteristics and needs through the MDS every month, facilities are able to anticipate staffing needs and keep them continually up to date and in line with their needs.

Examples of The Evangelical Lutheran Good Samaritan Society's process for self-regulation of staffing standards are described on the charts appended. The median total direct nursing hours are plotted against Medicaid payments for that facility's resident populations, as are those staffing levels suggested by HCFA's criteria for the RUGS. As you can see, the Society is funding levels of staff well above the Medicaid payments, which account for 62% of our residents. If arbitrary staffing standards were set at the levels HCFA criteria might suggest, one of these 67 bed facilities would have an annual funding shortfall of $178,379; the other facility, of the same size, would lose $260,669. We do not have the capability to sustain these costs.

But we must get serious about solving these problems at once. The current debate over minimum staffing ratios is not the answer. The single most important factor that must be considered in setting staffing levels is the clinical and personal needs of the residents. The consumer advocate's ratio

argument completely disregards the needs of residents, and hence would be completely inappropriate in most facilities.

But let's assume for a minute that ratios were put in place regardless of merit. Would nursing homes be able to meet those ratios? No, they would not. A sufficient pool of qualified and employable people to meet the current need simply does not exist today.

But for the sake of argument, let's assume there is no drastic labor shortage. If there is no shortage, and we start our employees at a higher competitive wage (enough to recruit and retain against privately funded market competitors) where would this money come from? As I noted, the Government pays for nearly 80% of all nursing home residents, and only 3% are paid by private insurance. There is not room for cost shifting in the nursing home equation. Will state and Federal governments meet their responsibilities to increase payments? Not likely - - in fact the trend is the opposite. With the new PPS and the repeal of the Boren amendment, we now have fewer guarantees that payment rates will meet the cost of care. We estimate the cost of paying for the staff for even the minimum NCCNHR ratio would be over $6 billion every year.

But let's again assume the government does live up to its responsibility to provide adequate resources, then, what is the most logical and efficient way to determine appropriate staffing levels? Is it the establishment of minimums without underlying data to tie them to need? No it is not. The most appropriate and efficient way to determine staffing levels is to staff to the level of acuity or need as determined by the clinical and psychosocial needs of the residents in each facility.

Why then, if we are not willing to address the first two barriers to solving this problem, should we move immediately to demanding an inappropriate and unreachable staffing ratio of providers? Those of us who work on the front lines of caregiving know all too well that this is not a workable solution. Fully funded staffing at the appropriate level for the acuity of the residents in each facility is the only intelligent solution. Even this will not be possible unless we address the labor shortage and payment issues.

So, as I see it, the staffing crisis must be addressed in three sequential steps. First we must find creative ways to increase the labor pool. Second we must link adequate payment to appropriate staffing. And third, we must develop appropriate and attainable staffing standards based upon the needs of the residents in each facility.

In closing, I have worked my entire life to provide care for the most needy in our society. I have never seen a staffing crisis as severe as this. It is being exacerbated by lowered payments, increased regulation and penalties, and a continued public attack on nursing facilities.

It is imperative that we face the staffing problems head-on, and that providers, residents, paid consumer advocates, regulators, and policymakers' work together toward thoughtful solutions that work explicitly to benefit the residents we serve. The residents we are caring for are depending on that cooperation.

**Steps Policymakers Could Take to Help Now**

Following are a few concrete steps that policymakers can take today to relieve some of the pressures causing the staffing crisis:

- Establish funding requirements that recognize the cost and importance of adequate staff.
- Enact upward mobility scholarships to provide additional training for caregivers to receive

advanced licensure and certifications.

- Extend and improve the Work Opportunity Tax Credit (WOTC) for hiring disadvantaged workers. Enact tax credits for training workers in CNA and other career fields.
- Cultivate careers in long term care. Work with universities to develop and promote curricula for long term care nurses. Promote long term care as an underserved career field within academic centers.
- Develop a research agenda to support advances in caregiving, i.e. Alzheimer's care, end of life care, geriatric nutrition, and dementia.
- The Telecommunications Act of 1996, was passed by Congress to provide funding for rural education and not-for-profit healthcare organizations to improve the communications infrastructure in their rural facilities. This act creates a universal service fund that is funded by an additional tax on telephone bills. Our concern is that long-term care is not considered a healthcare organization under the criteria for this funding. We consider this to be a critical oversight especially in light of the rural nature and enormous governmental mandate for data and information in long term care.